(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - Use DD Form 2005.)

EYEWEAR PRESCRIPTION

DATE	ACCOUNT NUMBER	ORDER NUMBER

TO: *(Lab)*

FROM:

NAME *(Last, First)*	SSN	GRADE

ADDRESS/UNIT	PHONE

ADDRESS CONTINUED	SHIP TO: ☐ CLINIC ☐ PATIENT

CITY, STATE, ZIP

AD	RES	NG	RET	OTHER*	A	N	AF	MC	CG	PHS	OTHER*

FRAME	EYE	BRIDGE	TEMPLE	COLOR	

PD DIST / NEAR	LENS	TINT	MATERIAL	PAIR	CASE

	SPHERE	CYLINDER	AXIS	DECENTER	H PRISM	H BASE	V PRISM	V BASE
R								
L								

MULTIVISION

	NEAR ADD	SEG HT	TOTAL DECENTER
R			
L			

LAB USE

PRIORITY	TECH INITIALS

SPECIAL COMMENTS/JUSTIFICATION *(*Use this space to specify blocks marked "Other.")*

PRESCRIBING OFFICER/AUTHORITY	SIGNATURE

DISTRIBUTION: **ORIGINAL** - Retained by Lab. **COPY 1** - Returned with eyewear. **COPY 2 -** Entered in health record.